Supreme Court

JOHN HANCOCK [illegible]
Collector,

Appellant,

vs.

RHODA S. GAUNT, individually and as [illegible]
of the Estate of James A. Gaunt, [illegible]

Appellee.

On Petition for Writ of Certiorari to the United States Circuit Court of Appeals for the Second Circuit.

BRIEF OF RHODA S. GAUNT IN OPPOSITION

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1946.

No. 1386.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,
Petitioner,

—against—

RHODA S. GAUNT, individually and as administratrix of the Estate of James A. Gaunt, Jr., deceased,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SECOND CIRCUIT.

BRIEF OF RHODA S. GAUNT IN OPPOSITION.

I.

Opinions Below.

The opinion of the District Court, dated April 17, 1946, and a supplement thereto, dated July 23, 1946, have not been published in the Federal Supplement. Nor, as of this date, has the opinion of the Circuit Court of Appeals, rendered March 31, 1947, been published in the Federal Reports. However, as indicated in the petitioner's brief, all of these opinions have been published in C. C. H. Life Cases and all of them appear in the Record certified by the Clerk of the Circuit Court of Appeals.

II.

Jurisdiction.

The jurisdiction of this Court is invoked under Judicial Code, Section 240 (a) as amended, U. S. C., Title 28, Section 347; 28 U. S. C. A., Section 347.

III.

Statement.

The respondent is the mother of the decedent, James A. Gaunt, Jr., and the duly appointed administratrix of his estate. At the time of instituting this action on May 31, 1944 she was, and for many years prior thereto had been, a resident of Waterbury, Connecticut, where she resided with her husband and children.

The petitioner is a Massachusetts corporation which is engaged in the life insurance business and which had, for many years prior to the institution of this suit, maintained an agency or district office in Waterbury, Connecticut, where it employed various persons, including one Morris Kelman, as life insurance salesman.

During the summer of 1943, the decedent, James A. Gaunt, Jr., was an employee of the French Manufacturing Company in Waterbury. He was then twenty-one years old, insuring age twenty-two, having been born on December 9, 1921.

James was contacted on two occasions in July, 1943 by the aforesaid Morris Kelman, agent of the petitioner, who did his best to sell a life insurance policy in substantial amount to the boy. Kelman recommended three policies of insurance, two of which were in the face amount of $15,000, one of the latter being designated by the petitioner as a "$15,000 Endowment at 85". At the same

time James was giving serious consideration to proposals of an agent of the Metropolitan Life Insurance Company who was also making efforts to sell him a $15,000 policy.

The negotiations between James and the two agents were suspended temporarily while James took a short vacation. However, during this vacation he discussed with his mother the various proposals of the two agents and it was tentatively decided, subject to a proposed further conference with Kelman, that he would apply to the petitioner for the so-called "$15,000 Endowment at 85" policy.

Accordingly, on August 3, 1943, the agent Kelman again appeared at the Gaunt home and a further discussion about the proposed insurance was had during which Kelman advised the applicant that it would be best for him to pay in advance the first quarterly premium which, including the additional premium for accidental death benefits, amounted to $79.05. In advocating this advance payment Kelman advised the applicant that he would benefit thereby in that, if he were insurable, his insurance would run from the date of the medical examination, which, it was proposed, would be made that afternoon. Kelman further advised the applicant that if he did not pay his first premium in advance the insurance would not start to run until the delivery of the policy.

James listened to the agent and, as the result of their discussion, he cut off his negotiations with the Metropolitan Life Insurance Company, agreed to apply to the petitioner for its "$15,000 Endowment at 85" policy, with additional accidental death benefit provision, and further agreed to pay the first quarterly premium of $79.05 in advance, *i. e.*, that very day.

James and the agent Kelman then left the Gaunt house and went to a local bank where the required sum of $79.05 was paid to the agent by James and, after Kelman had written in answers to various questions put to the applicant on the petitioner's standard form of application blank, James wrote his signature in the space pro-

vided on the blank for that purpose. In return, Kelman handed him an instrument designated "Temporary Receipt" which is referred to in the petitioner's agency manual and other literature as a "Binding Receipt". The respondent was designated in said application as the beneficiary of the life insurance applied for.

This application form contained a question the answer to which was of the greatest importance to the applicant. The question, designated as No. 12 on the form, requested the applicant to signify whether he elected to have his insurance effective as of the date of Part B (this being the medical examiner's form which was annexed to and formed a part of the application), or as of the date of issue of policy. When Kelman filled in the answers to the various questions on the application form, as aforesaid, he left Question 12 unanswered. According to other provisions in the application form, if this question remained unanswered the effect was to put the insurance in force as of the date of Part B.

The date of Part B, *i. e.*, August 3, 1943, was the date which both Kelman and Gaunt had determined upon as the effective date of the insurance. Nevertheless, after James had signed his name on the application, Kelman, without the applicant's knowledge and contrary to the understanding which he had reached with the applicant, inserted an answer to Question 12 in which he indicated that the applicant had elected the date of policy issue as the effective date of the insurance. Whether this inequitable act was done by Kelman at the bank or at some later time in the privacy of his own office is not known. However, the fact is that it was done, and it was done as the result of motives on the part of Kelman which are not relevant here but which were clearly disclosed by his own testimony on the trial.

After completing their business at the bank Kelman and the applicant went to the office of one of the petitioner's medical examiners in Waterbury, one Dr. Sandulli, and there the applicant was examined and given a clean

bill of health by the examiner. Dr. Sandulli filled in and executed Part B of the application that afternoon, *i. e.*, August 3rd, 1943, and the following day delivered the papers to the Waterbury agency of the petitioner. Several days later these papers were forwarded to the petitioner's home office in Boston where they were examined, along with certain other relevant papers pertaining to the applicant's insurability, by members of the petitioner's underwriting department.

A few days after his dealings with Kelman on August 3rd, James decided to give up his job in Waterbury and to go to the Pacific Coast. Accordingly, he left his employment on August 15th and on August 19th started for the West Coast by bus. Prior to leaving Waterbury, he had notified a friend in Chicago that he would stop over to see him in that city.

After his departure the respondent received two written communications from her son, one postmarked Chicago, Illinois, and the other postmarked Milwaukee, Wisconsin. Apparently all was going well, but on the early morning of August 26th she received the stunning news that her son's dead body, with a bullet wound in the head, had been found by the tracks of the Chicago, Milwaukee, St. Paul & Pacific Railroad at a point several miles west of Milbank, South Dakota.

After what we have claimed was needless and unreasonable delay in underwriting operations, the application of James A. Gaunt, Jr. finally came, on the morning of August 26th, 1943, to the desk of the petitioner's chief medical underwriter and a stamp mark, indicating his approval of the application, was placed thereon. However, shortly thereafter the petitioner learned of the applicant's death, and thereupon, and for that reason alone, ceased all activities with respect to underwriting and policy issue, and subsequently refused, on various grounds, to recognize the respondent's claim for the insurance proceeds, one of the grounds being that it had not approved of the application before the applicant's death.

As the result of the petitioner's attitude the present suit was instituted. The complaint, which was drawn in four counts, embraced two essential theories of recovery, (a) that the application and binding receipt, executed under the circumstances stated above, constituted, if the applicant were insurable, a contract of life insurance which was in full force at the time of his death, and (b) that on the basis of the facts which we were prepared to show, the petitioner was liable in tort or implied contract as the result of its negligent delay in failing to act upon the application within a reasonable time after August 3rd. On the express contract theory it was obviously proper that the suit be brought by the respondent in her individual capacity but, under the tort or implied contract theory, the majority of cases appear to require that the action be prosecuted in the name of the representative of the applicant's estate. Accordingly, because of the different theories relied upon by us for recovery, suit was brought in Mrs. Gaunt's name both individually and as administratrix of her deceased son's estate.

In its Finding of Facts the trial court made an exhaustive review of the events which occurred in the time which intervened between the signing of the application and the applicant's death, and thereupon concluded that, although there were two substantial unexplained delays totaling about ten days in the underwriting operations, the respondent had not proven that there was an overall *unreasonable* delay. Although we could not agree with this conclusion, we recognized that it was a conclusion of fact which it was within the province of the trial judge to reach and that there would be little to gain by seeking a review of the evidence on that point. Accordingly, we abandoned the tort and implied contract claims which were set forth in different forms in the Second, Third and Fourth Counts of our complaint and our client appealed to the Circuit Court of Appeals from the District Court's judgment only as it affected her rights as an

individual under the express contract claim, this claim having been set forth in the First Count.

In the Circuit Court of Appeals it was, in substance, our contention that the trial court made several serious errors of law in deciding the issue formulated under the First Count and that we were not only entitled to recover the face amount of the policy under a correct decision upon that issue, but that we were also fully entitled to recover the additional amount of the accidental death benefits plus interest on the unpaid total proceeds from the date the obligation should have been met to the date it is actually met.

Against our contention that the record failed utterly to support the District Court's finding that the petitioner had proven that a person had killed the insured, with the deliberate intention of killing him, the Circuit Court of Appeals decided that the record supported such a conclusion. Furthermore, the Circuit Court held that although the insured was never advised by Kelman that the company's standard form of accidental death provision contained numerous exceptions to the purported coverage for accidental death, including an exception denying coverage if death resulted from the intentional act of another, the beneficiary could not recover the additional $15,000 although her son's death was, in law, an accident. The appellate court did, however, rule that the contract entered into between himself and the company was a contract of life insurance which was in full force and effect at the time of his death and that therefore the respondent should recover $15,000, representing the face amount of the insurance.

IV.

Summary of Argument.

A. In the light of the facts found, Connecticut law as well as the law of other jurisdictions required reformation of the contract.

B. There are no Connecticut decisions which are controlling with respect to the construction of the specific type of life insurance contract involved in this case.

C. Decisions closely in point in other jurisdictions as well as long-accepted principles of law as enunciated by Connecticut courts and in all other states overwhelmingly support the decision of the Circuit Court of Appeals.

V.

A.

In the light of the facts found, Connecticut law as well as the law of other jurisdictions required reformation of the contract.

This issue is concerned with the all-important answer to Question 12 in the application (Record, Part I, page 40).* In that question the applicant was given the right to choose whether his insurance should go into force on the date of Part B, the medical examination, or on the date of policy issue. He could elect the date of Part B by simply inserting a checkmark in the first of the two options given

* Throughout this brief, reference to Part I of the Record means the Appendix to Brief of Appellant, reference to Part II means Appellee's Appendix and reference to Part III means the record of the proceedings in the U. S. Circuit Court of Appeals, Second Circuit.

in Question 12. Or he could accomplish the same result by checking neither of the options and simply leaving the question unanswered. This is so because Section B of that portion of the application which follows Question 18 provides that when the first premium or installment thereof is paid in advance the insurance shall be effective from the date of Part B *unless* the applicant specifically elects otherwise in answering Question 12.

An examination of the Finding and Amendments to Finding reveals the following facts:

1. When the applicant paid to the petitioner's agent Kelman the sum of $79.05, representing the first quarterly premium on the insurance, he did so upon the representation of Kelman that the insurance would be effective from the date of the medical examination if he were insurable on that date (Record, Part I, page 44, Paragraph 13).

2. Such advance payment was advantageous to the company (Record, Part I, page 44, Paragraph 14).

3. Kelman stressed the advantages of coverage from the date of medical examination and thereby obtained the advance payment of premium, but did not so mark the application as to call for coverage from the date of the medical examination (Record, Part I, page 45, Paragraph 15).

4. Both the applicant and Kelman intended that the applicant should be covered from the date of the completion of Part B of the application by the examining physician (Record, Part I, page 71, Paragraph 4).

5. Nevertheless, after the application was signed by Gaunt, Kelman marked Item 12 of the application to indicate insurance effective as of the date of issue of the policy (Record, Part I, page 45, Paragraph 15).

6. Kelman so marked Item 12 without the knowledge

or consent of Gaunt (Record, Part I, page 71, Paragraph 2).

7. The marking of Item 12 by Kelman to indicate that insurance was to be effective from the date of policy issue was due to a mutual mistake on the part of Gaunt and Kelman (Record, Part I, page 73, Paragraph 75).

The Law on Reformation.

> "Where an action arises upon an instrument which, from mutual mistake, or mistake on one side and fraud or inequitable conduct on the other, fails to express the actual agreement, it is a matter peculiarly within the jurisdiction of a court of equity to reform such contract and grant relief in accordance with the intention of the parties * * *."
>
> *53 C. J., Reformation of Instruments,* Section 27.
>
> "Where a written agreement is not in conformity with the actual intention of the parties in a material matter, a court of equity will reform the writing in accordance with that intention if innocent parties will not be affected thereby. The jurisdiction is confined to writings, but as to them it is clear."
>
> *Williston on Contracts,* Revised Edition, Section 1547.

See

> *Couch, Cyclopedia of Insurance Law,* Volume 6, page 4991.

The rule in Connecticut is similar to that of other jurisdictions and applies to insurance contracts as well as to other written agreements.

> *Olmsted* v. *Olmsted,* 38 Conn. 309 (1871);
> *Reiner* v. *Maier,* 96 Conn. 566, 114 Atl. 657 (1921);
> *Back* v. *Peoples National Fire Insurance Co.,* 97 Conn. 336, 116 Atl. 603 (1922).

Another Connecticut case and one which is strikingly in point in the present situation is *Town of Enfield* v. *Clark L. Hamilton, et al.*, 110 Conn. 319, 148 Atl. 353 (1930).

Reformation and recovery on the reformed agreement may be had in the same action.

29 American Judisprudence, Insurance, 255.

This insurance company has, ever since the District Court's judgment was rendered, attempted to disown Kelman and, by the most devious methods, to get around the District Court's findings relative to Kelman's opprobrious conduct. Thus, we have the spectacle of this major company denying all responsibility for the acts of its agent. So, cloaked with a fake mantle of innocence, it bids for sympathy on the ground that the home office naively assumed that the contract called for insurance effective on date of policy issue. It is inconceivable that any court would thus permit a principal to so divest itself of liability for the dishonorable acts of one whom it has sent out into the public, ostensibly as an honest and qualified representative, to gather business for the principal's benefit. Not one of the cases cited by the petitioner upholds such an unthinkable proposition and the cases cited above are a direct answer to it.

In addition to the law of agency, general principles of estoppel prevent the company from successfully pressing for such an unfair advantage.

> "The doctrine of equitable estoppel precludes a person from maintaining a position or attitude inconsistent with another position or attitude which is sought to be maintained at the same time or which was asserted at a previous time, and, as a general rule, where a person has, with knowledge of the facts, acted or conducted himself in a particular manner, or asserted a particular claim, title, or right, he cannot afterward assume a position inconsistent

with such act, claim, or conduct to the prejudice of another who has acted in reliance on such conduct or representations."

31 C. J. S. 341.

Also in point on the subject of estoppel are:

Seymour Mfg. Co. v. *Derby Mfg. Co.*, 94 Conn. 311, 109 Atl. 395 (1920);
Gagner v. *Petrauskas*, 112 Conn. 307, 152 Atl. 145 (1930);
31 C. J. S. 345, 346;
Vance on Insurance, Second Edition, page 451.

A famous case which concerned facts precisely analogous to these and which resulted in an outright repudiation of the insurer's efforts to divorce itself from the acts of its dishonest agent is *McMaster* v. *New York Life Insurance Co.*, 183 U. S. 25, 39 (1901).

One of the most astonishing contentions by this petitioner is the claim (its brief, page 19) that "the application should not be reformed since the applicant must stand responsible for the content of his application." This bland assertion is made notwithstanding the undisputed fact that the application in this case was altered by the petitioner's agent after it left the applicant's hands and wholly without his knowledge. None of the cases cited by the petitioner is helpful to it. None of the cases it cites is an action in equity for reformation. Furthermore, that ancient refuge of insurers, *i. e.*, that a prospect must be deemed to have read and understood every complicated document which an insurance agent has temporarily placed in his hands was of no avail to the company which tried to hide behind it in *Town of Enfield* v. *Clark L. Hamilton, et al., supra*, page 11.

The curious effort of the petitioner to bind the Circuit Court of Appeals to the law of Massachusetts such as expressed in the *Bogosian* case would be futile even if that

case dealt with the principles of reformation, a subject which it does not, in fact, even touch upon.

On page 20 of petitioner's brief, the claim is made that the respondent's prayer for reformation was denied by the District Court. This is a flat misstatement. While it is true that the District Court did not specifically order a reformation, the facts it found and the conclusions it reached could lead to no other result. It is perfectly plain that the reason it did not order reformation was because such a gesture would have been futile inasmuch as its erroneous construction of the contract prohibited a recovery by the respondent in any event. However, what the District Court did do was to find that the contract set forth upon the application form, *as it was executed by the parties and before the fraudulent alteration by Kelman took place,* left Question 12 unanswered and thereby effected an automatic election of the date of Part B as the date the insurance was to go into force. Thus, neither the District Court, had it found in the respondent's favor, nor the Circuit Court of Appeals, in ruling for her, was obliged to order a reformation, *for the reformation had already been made in the District Court's finding.* Contrary to the insinuation in the petitioner's brief, page 20, it would appear that the Circuit Court of Appeals was fully "conscious" of what it was doing.

It seems hardly necessary to comment upon counsel's reference to Section 4182 of the Connecticut General Statutes, Revision of 1930. Nothing in this section prohibits preliminary contracts such as are entered into every day by the companies doing business in Connecticut, nor is there anything in this case which indicates that the petitioner's standard forms of policy contained any provisions contrary to those set forth in its preliminary agreement. On the other hand, if the petitioner means to imply that the latter is so, its present attempt to hide behind the statute is not one likely to elicit sympathy. In any event, there is a considerable body of law which holds that insurers who do write contracts in violation

of statutory specifications cannot, in suits brought against them by policyholders, avail themselves of the statutory provisions which they have deliberately violated.

> *Armstrong* v. *Western Manufacturers Mutual Insurance Co.*, 95 Mich. 137, 54 N. W. 637 (1893); *Wojtzak* v. *Hartland Farmers Mutual Fire Insurance Co.*, 200 Wis. 118, 227 N. W. 255 (1929).

The purpose of these statutes is to protect the public against unfair practices by insurers rather than to provide the companies with technical defenses in suits such as this.

> *44 C. J. S.* 1053.

B.

There are no Connecticut decisions which are controlling with respect to the construction of the specific type of life insurance contract involved in this case.

So far as we have been able to ascertain, the Connecticut courts have never been called upon to resolve an issue involving ambiguous or conflicting provisions in a temporary or preliminary contract of life insurance, *i. e.*, the type of contract which exists between the date of application or medical examination and the date of policy issue or delivery. Thus, the impassioned tirades which appear throughout the petitioner's brief wherein (particularly, as at page 30) the petitioner's counsel calls the Circuit Court of Appeals "unreasonable, negligent and arbitrary" and otherwise incompetent, for failing to apply Connecticut law are astonishingly inappropriate. Not one of the cases cited on pages 29, 30 and 31 which are claimed by petitioner's counsel to support his notion of the Circuit Court's attitude and aptitude gives the slightest indication that the highest tribunal of Connecticut would

reach a different conclusion from that of the Federal Court. The case of *Swentusky* v. *Prudential Insurance Company,* 116 Conn. 526, 165 Atl. 686 (1933), upon which the petitioner places chief reliance was an action in tort in which the plaintiff charged unreasonable delay by the insurer in acting upon the application. The full first premium was *not* paid in advance and there was no issue whatsoever as to whether any insurance contract was in force from the date of the application. In fact, it is perfectly obvious that both the litigants and the court assumed that such was not the case.

There having been no applicable local law specifically governing the question of construction, the Circuit Court of Appeals was entirely correct in applying general law.

Terry v. *New York Life Insurance Co.,* 104 F. (2d) 498 (C. C. A. Mo. 1939);

American National Insurance Co. of Galveston, Texas v. *Belch,* 100 F. (2d) 48 (C. C. A. Va. 1938);

Bowen v. *New York Life Insurance Co.,* 33 F. Supp. 705 (D. C. Mo.), affirmed 117 F. (2d) 298 (C. C. A. Mo.), certiorari denied 61 S. Court 1102, 313 U. S. 583, 85 L. Ed. 1539 (1940);

New England Mutual Life Insurance Co. v. *Mitchell,* 118 F. (2d) 414 (C. C. A. Va. 1941), cert. denied 62 S. Court 60, 314 U. S. 629, 86 L. Ed. 505 (1941);

Zephyr American Corporation v. *Bates Mfg. Co.,* 128 F. (2d) 380 (C. C. A. N. J. 1942);

Hornstein v. *Cramer Bros. Freight Lines,* 133 F. (2d) 143 (C. C. A. Pa. 1943).

C.

Decisions closely in point in other jurisdictions as well as long-accepted principles of law as enunciated by Connecticut courts and in all other states overwhelmingly support the decision of the Circuit Court of Appeals.

It is our contention that the application, with Question 12 found unanswered by the District Court or a corrected answer supplied in accordance with our prayer for reformation, together with the temporary or binding receipt, constituted a contract of insurance which was in full force and effect between August 3, 1943 and the time of the applicant's death on or about August 25, 1943. The word "temporary" as used in our complaint was obviously intended as meaning "preliminary" in the sense that the early contract, evidenced by the application and binding receipt, would later be supplanted by the usual form of policy. Thus, the applicant being fully insurable, the insurance was in force on a permanent basis from the date of Part B, the medical examination.

The significant portions of the application and binding receipt which are to be considered under this issue are Question 12 in the application, Section B in the printed portion of the application following Question 18 and all of the material in the binding receipt. As the latter two are substantially the same in content and legal effect, we ask the Court to assume that we are referring to both whenever reference is made to Section B of the application.

The action of any kind of insurance company to which application for a policy of insurance is made must necessarily be predicated upon two things: (a) the representations made by the prospective insured in his application, and (b) information obtained by company

representatives, employees and investigators, both being subject to review by company underwriters before a final decision is made. This is true whether the company be a fire, casualty, marine, or life insurer. These steps are necessarily time-consuming and many days or many weeks may elapse between the date of application and the date of the company's final action thereon. In that interim period loss or injury to the proposed subject matter of the contract may occur. Therefore, in order to protect against this interim danger, it is the common practice of all types of insurers to enter into preliminary or temporary contracts which insure against the occurrence of loss pending the issuance of a formal policy, the only condition being that the event insured against shall, as the result of the insurer's subsequent investigation and review of the file, be determined to have been a satisfactory insurable risk on the date of the application. If it is found to be such, a formal policy is then issued to the insured bearing the date of the application as its effective date.

44 C. J. S., Insurance, 956, *et seq.;*
29 American Jurisprudence, p. 158, Section 143.

This temporary or preliminary arrangement has distinct advantages to both insured and insurer. The applicant gets the needed protection immediately, subject only to confirmation of insurability as of the effective date of the contract. The insurer, on the other hand, has the advantage of immediately binding the prospect and eliminating the risk of losing him to another company, such as would be the case if no contract were to come into force until after the sometimes lengthy investigation and underwriting review of the file are completed. An additional advantage of the highest importance to the insurer lies in the fact that a premium payment is ordinarily made at the time the preliminary binding arrangement is entered into. Thus if the insured later refuses

to accept his policy, the company is in a position to retain at least the first premium payment as a matter of right and thereby compensates itself for its underwriting costs even though the insurance may be allowed to lapse by the insured after the initial premium period has expired.

In the present case the trial court specifically found the existence of these mutual advantages. (Finding, Paragraph 14, Record, Part I, pages 44 and 45). The court, however, closed this paragraph of the Finding with the following sentence: "It is, however, undesirable, from the standpoint of the defendant, to permit any binding contract to be entered into prior to the completion of the underwriting activities and the final passing upon the risk by the home office." Conceding that certain of the petitioner's representatives made this claim during the trial, it is incomprehensible to us that the court could have adopted it. For one thing it is quite inconsistent with the preceding portion of Paragraph 14 and with other portions of the Finding. Furthermore, as a matter of law it cannot be true, for this reason: If the risk is an insurable one according to the company's standards, it will always be accepted and a policy issued, whereas if the risk is an uninsurable one it can, and will be, refused. In the latter case if a loss should occur in the interim before final action by the company's underwriters, no court could possibly force the insurer to accept the risk or to pay for the loss which has so occurred. We believe that this sentence in the Finding is one indication of the trial court's misconception of the type of contract with which we are here concerned.

The hundreds of cases and the many articles and textbooks written by authorities on this subject show that in life insurance as well as in other kinds of insurance there are essentially two types of negotiations which occur between prospects and insurers prior to the issuance of a formal policy. One contemplates a simple form of

application which is to be without value or legal significance to the applicant until final action is taken by the company. It is usually not accompanied by a premium payment. This type of initial proceeding formerly obtained to an almost exclusive degree in the life insurance business, as may be attested by a review of many of the earlier cases. In legal concept it is no more and no less than an offer which, until accepted by the other party, cannot ripen into a contract. It is obviously the type of situation which is contemplated in the second sentence of Section B, following Question 18 in the present application, which provides as follows:

> "If payment of the said premium was not made when this application was signed, any such policy will take effect as of its date of issue, and only if I have not consulted or been treated by a physician or other practitioner since the date of the completion of said Part B, and only if the policy is delivered to and received by me and the first premium or installment thereof is actually paid while I am alive and in sound health, and in any case, such delivery and payment shall constitute an acceptance of the policy and of all its conditions."

The other type of negotiation contemplates a preliminary or temporary binding arrangement such as has been briefly discussed hereinbefore. It is this type of immediate insurance protection which, we contend, is obviously meant to be provided, at the election of the applicant, by the wording of Question 12, the first sentence of the aforementioned Section B of the application and the "temporary" or "binding" receipt, with which we are dealing in the present case.

Evidence of the common practice among life insurers to enter into binding preliminary contracts, conditioned only on insurability, is found in the standard form of life insurance application set forth on page 535 of the Prentice-Hall "Insurance Principles and Practices" by Riegel and

Loman. And we would also refer the Court to a standard life insurance text, which contains the following:

> "When it is agreed between the parties, as is frequently the case, that the contract shall be in force from the date of the physical examination, provided the insured's health conforms to the company's standards, the policy dates from the examination regardless of the time delivery is made. To make the insurance effective from the date of examination, the companies require the payment of the first premium at or prior to the examination. Delivery of the policy in such a case has no significance other than to furnish the insured a written copy of the agreement. Death of the insured prior to receipt of the policy will not affect his right to recovery, nor is it necessary that the company actually have acted upon the application provided the insured was in such health as to pass the examination at the time it was made."
>
> *Magee, Life Insurance,* p. 395 (Published 1939 by Business Publications, Inc.).

A further examination of the cases demonstrates that these preliminary or temporary contracts of life insurance, which have been devised by insurance company lawyers and later incorporated into forms adopted by the companies for use in business practice, may be subdivided into two different forms or types.

See articles:

> *Illinois Law Review,* Vol. XXXIII, No. 2, June 1938, page 180;
> *Yale Law Journal,* Vol. XLIV, page 1133.

The first of these provides, in substance, that:

> "The insurance applied for shall be effective from the date of the application or medical examination provided that the risk is approved at the home office of the company."

The second type provides, in substance, that:

> "The insurance applied for shall be effective from the date of the application or medical examination provided that the Company is satisfied that on the date of such medical examination the applicant was insurable according to the company's rules for the amount and plan applied for."

An analysis of Section B, following Question 18, of the present application, together with the provisions of the "temporary" or "binding" receipt demonstrates that the petitioner has sought to combine both of these types of provision in one form of agreement. So far as can be ascertained from the court decisions, The John Hancock Mutual Life Insurance Company is the only company which has attempted to effect such a unique, confusing, unreasonable and unnecessary combination of conditions.

The law relating to these three types of agreement will be discussed in the order in which they have been mentioned.

1. Provisions making insurance effective on the date of the application or medical examination if the application has been "accepted" or "approved" at the home office.

In most of the cases which have arisen where companies using this form of application and binding receipt have sought refuge behind it, on the claim that "approval" is a condition precedent to liability if death occurs in the period intervening between the date of application and the date of final company action, the insurers have been rebuked, and the conditions which they have unsuccessfully sought to impose upon applicants under such forms have been scathingly denounced by the courts.

In *Hart* v. *Travelers Insurance Company*, 258 N. Y. S. 711, 236 App. Div. 309, affirmed 185 N. E. 739, 261 N. Y.

563 (1932), and followed in *Buono* v. *Prudential Insurance Company of America*, 267 N. Y. S. 972, 240 App. Div. 898 (1933), the suit was on an alleged temporary contract of insurance based on an application and binding receipt, of the kind here under discussion, which was issued on August 15, 1927. The applicant died on August 16, 1927, before the company had acted in any manner upon the application.

In answering the contention of the insurer that the applicant was never insured because his application had not been "accepted", the court said:

> "* * * The insurance company now states in effect that the object of this provision was to enable the insurance company to collect premiums for a period during which there was no insurance and consequently no risk. By the first subdivision of this binder the company agreed that, if the full premium was paid when the binder was signed the insurance would be in force from the date of the receipt. The money having been paid, there was a complete contract between the parties, and, if this is so, this action may be maintained. Furthermore, if the construction to be placed upon this binding receipt is not that Levy was to be insured from the date of the binder until the formal policy was issued or the risk declined by the defendant, then it must be said that this binding receipt is at least ambiguous, and, if so, it should be construed against the company; it having been drawn up by the agent of the company upon its printed form. I therefore advise that the judgment be reversed on the law, with costs, and judgment directed in favor of the plaintiff for $5,000, with interest from August 16, 1927, with costs."

It is true that in three New York decisions the courts appear to have adopted an approach somewhat different from that used in the *Hart* and *Buono* decisions. *Corning* v. *Prudential Insurance Company of America*, 288 N. Y. S. 661, 248 App. Div. 187, affirmed 273 N. Y. 668, 8 N. E. (2d)

338 (1937); *Arcuri* v. *Prudential Insurance Company of America,* 290 N. Y. S. 567, 248 App. Div. 501 (1936); *Hughes* v. *John Hancock Mutual Life Insurance Company,* 297 N. Y. S. 116, 163 Misc. 31 (Municipal Court, 1937); judgment, as modified by the Appellate Term, affirmed, 3 N. Y. S. (2d) 899, 254 App. Div. 570 (1938). The facts in these cases may be distingushed from those in the *Hart* and *Buono* cases. For instance, in the *Corning* case, which is, incidentally the only one of the three that went to the Court of Appeals, the application was declined the very day that the applicant died. The novel feature of these decisions is, however, the ruling that an ambiguity isn't important unless the conflicting provisions appear in separated clauses in the application form. However, this artificial and, we submit, wholly unjustifiable, distinction flies squarely in the face of the overwhelmingly accepted rule that all ambiguities, inconsistencies and repugnancies must be resolved against the insurer and in favor of the insured, the former having it clearly within its power to make its contracts clear and unequivocal in meaning. If a contract contains language which conflicts with other language therein, and thus makes the meaning of the entire instrument uncertain, it would seem to be wholly irrelevant whether one of the provisions immediately follows the other or whether it appears in an entirely different part of the contract.

Another case concerned with this type of "approval" condition is *Starr* v. *Mutual Life Insurance Company of N. Y.* (Wash.), 83 Pac. 116 (1905). In that case the application and binding receipt were executed on November 30, 1903. The insured died on December 8, 1903 before any action of acceptance or rejection had been taken by the company.

In overruling the contention of the petitioner that no insurance was in force because the company had not approved the application, the court said:

"* * * If he lived until the application was approved

> and a policy issued, it would seem a matter of indifference to him whether he had been insured during the interim between the date of the application and the date of the issuance of the policy. On the other hand, if he died before the application was approved and the policy issued, his beneficiaries would derive no benefit from the insurance. The chief object of the provision would, therefore, seem to be to enable the insurance company to collect premiums for a period during which there was in fact no insurance, and consequently no risk."

The insertion of a clause in a premium receipt purporting to provide insurance pending action by the insurer upon the application by making the same conditional upon approval or acceptance at the home office has been characterized as a mere "trick" on the part of an insurance company to deceive an applicant into the belief that he has temporary insurance and thereby induce him to part with his money in advance of the issuance of the policy.

> *Francis* v. *Mutual Life Insurance Co.*, 55 Ore. 280, 106 P. 323 (1910).

In an Ohio suit involving similar forms the plaintiff was allowed to recover.

> *Prudential Insurance Company of America* v. *Howard*, 18 Ohio L. Abs. 688 (1935).

We do not necessarily subscribe to all of the dictum in that case but the ultimate decision appears to be a sound one. The case was decided on January 16, 1935 by the Ohio Court of Appeals, First District, Butler County. The decision is not printed in any published report. Neither was it rendered by the highest court in Ohio. However, it was expressly approved in an even more liberal decision rendered by the Supreme Court of Ohio, *Duncan* v. *John Hancock Mutual Life Insurance Company*, 137 Ohio St. 441, 31 N. E. (2d) 88 (1940), a case which will be hereinafter discussed in more detail.

2. Provisions making the insurance effective as of the date of the application or medical examination provided the applicant was, on such date, an insurable risk according to the company's standards.

In *Reynolds* v. *Northwestern Mutual Life Insurance Co.* (Iowa), 176 N. W. 207 (1920), the court had before it for construction an application which recited that if the first premium were paid the insurance should take effect from the date of the application "provided the said company in its judgment shall be satisfied as to my insurability, on the plan applied for, on the date of such medical examination."

The court decided, page 209, that:

> "Unless the application is, in the proper exercise of the company's rights, under the law and the contract, rejected, and the insurance refused, the preliminary contract provides protection from the date of the medical examination, and if death results from some cause arising after the date of such examination, the company is liable upon the contract, according to its terms; but if the company, in the proper exercise of its legal rights, under the law and the contract, which it is unnecessary for us to define in this opinion, rejects the application upon the ground that the applicant is not insurable and returns the premium paid, no liability can arise thereunder. * * * The insurability of the applicant is, by the contract, made the test of the company's liability."

For other decisions in point the Court is respectfully referred to the following cases:

Stonsz v. *Equitable Life Assurance Soc. of U. S.*, 187 Atl. 403 (1936);

New York Life Insurance Co. v. *Abromietis*, 254 Mich. 622, 236 N. W. 769 (1932);

Wolfskill v. *American Union Life Insurance Co.*, 172 S. W. (2d) 471 (1943);
Western & Southern Life Insurance Co. v. *Vale* (Ind.), 12 N. E. (2d) 355 (1938);
Albers v. *Security Mutual Life Insurance Co.*, 41 S. D. 270, 170 N. W. 159 (1918);
Colorado Life Insurance Co. v. *Teague* (Tex.), 117 S. W. (2d) 849 (1938).

Many of the forms discussed in the foregoing cases under this topic provide that the evidence of insurability must be to the "satisfaction" of the company. These decisions are all in accord with the general principle of contract law which rules that where a contract provides that something must be done to the "satisfaction" of one party the condition is regarded as requiring no more than that the promissor shall "render performance which shall be satisfactory to the promisee if he exercises an honest judgment."

Williston on Contracts, Revised Edition, Sections 44, 675A;
Restatement, Contracts, Section 265.

For cases sustaining the validity of this proposition in insurance law, reference is respectfully made to:

Thompson v. *Postal Life Insurance Co.*, 226 N. Y. 363, 123 N. E. 750, 751 (1919);
Illinois Bankers Life Ass'n. v. *Palmer,* 176 Okla. 514, 56 P. (2d) 370 (1935);
Kahn v. *Continental Gas Co.*, 325 Ill. App. 1, 59 N. E. (2d) 524 (1945);
New York Life Insurance Co. v. *Dandridge,* 202 Ark. 112, 118-119, 149 S. W. (2d) 45, 134 A. L. R. 1519, 1534 (1941);
Union Life Insurance Co. v. *Bolin* (Ark.), 145 S. W. (2d) 734 (1941);

Sussex v. *Aetna Life Assurance Co.*, 33 D. L. R. 549, 552, 38 Ont. 365;
Kennedy v. *Occidental Life Insurance Co.* (Cal.), 117 P. (2d) 3 (1941).

3. The John Hancock forms of application and binding receipt.

These forms, if the decisions are any clue to the general trend of the business, are an innovation, something entirely new and different for applicants and prospects to contend with. Here the company not only provides that immediate insurance is contingent upon "satisfactory" proof of "insurability", but adds the further condition that the application must be "approved" at the home office, and then ties it all up very neatly by requiring that this "approval" must occur before the death of the applicant. Thus the company, as the result of the sly planning of its legal department, has attempted to place itself in a position to claim, if it wishes to hold the applicant to his agreement, that he is bound by a contract. On the other hand, if because of some development subsequent to the date of Part B (the medical examination), such as the death in the instant case, it does not wish to be bound by the papers, it can claim that the essential contract element of acceptance by the offeree, viz: "approval" of the application in this instance, is lacking, so that no contract exists. The petitioner, in all solemnity and, in fact, with quite a show of indignation, has stood pat on this unheard of proposition. By doing so, *i. e.*, by contending that the absence of an express final approval of the application at the home office precludes the existence of insurance from the date of Part B, the petitioner, in effect, shamelessly admits that the following are the necessary results if such a premise were to be upheld by the courts:

(a) Regardless of the fact that there is no doubt about

his insurability, if the applicant dies prior to approval he has never had any protection although the company has had the use of his money from the date of the binding receipt to the date of death and although it has, both orally and in writing, authorized its agents to delude prospects into the belief that immediate payment of the premium may give protection from the date of Part B.

(b) If the applicant lives and is "approved", his insurance protection starts only as of the date of such "approval" notwithstanding the fact that he has actually paid for such protection from the date of Part B.

Example: It is a well known fact that in practically all types of "ordinary" life insurance contracts, including "whole life" and "endowments" maturing in old age, no reserve begins to accumulate until the second or third year of the policy's existence. Thus all of the early premiums are used in payment for pure "protection". And in term insurance no reserve *ever* accumulates. Therefore, let us consider the example of the prospect who desires a large policy upon which the quarterly premium amounts to $3,000. He applies to the company, pays the first quarterly premium of $3,000 in advance, and elects to have Part B as the effective date of his insurance. The company takes approximately two months to investigate the risk—and it frequently takes this much time, or longer, according to the testimony of its own "experts" during the trial—and then "approves" the application and forwards the policy to the applicant. The applicant may not know it, and presumably doesn't because of the tricky wording of the application, but is it not perfectly plain that as to $2,000 out of the $3,000 so paid and retained by the company, the latter has given *absolutely nothing* in return?

(c) If the applicant lives but is declined, the company has had the use of his money in the interim period between the date of the binding receipt and the date of rejection without giving him anything in return therefor. Surely

the fact that the court found (Record, Part I, page 73, Paragraph 69) that this premium money is held in "suspense" at the district agency can be of no avail to the petitioner, for the instruments themselves in no way restrict the use of such monies once they have been received by the petitioner.

(d) Notwithstanding the contrary language in the binding receipt, application, rate book, agency manual and contrary instructions by the company to its agents, it would be impossible under any circumstances whatsoever for insurance to be in effect prior to the date of approval at the home office.

Surely, quite apart from the idea of fairness to the public, which does not seem to concern this petitioner, it should have used better judgment in the preparation of its forms. For it has had, in the very recent past, an experience which should have taught it a lesson. In *Duncan* v. *John Hancock Mutual Life Insurance Co.* (Ohio), 31 N. E. (2d) 88 (1940), cited *supra*, the situation was as follows: On September 9, 1937 Dell B. Duncan applied in writing for life insurance in the defendant company, accompanying his application with an advance premium payment, and receiving the customary receipt from the company. On September 24, 1937 Mr. Duncan became ill, and he died on or about September 29, 1937. The company denied liability and the beneficiary brought suit.

The receipt issued by the company to the applicant contained the following language:

> "It is understood and agreed that no liability is assumed by the company on account of this payment nor until it shall issue a policy, but if death occurs after the date of the application from which this receipt is detached and prior to the date of issue of such policy, payment in accordance with and subject to the conditions and provisions of the policy applied for shall be made; provided the applicant is insurable under the company's rules and the applica-

> tion is approved and accepted by it at its home office as to plan, premium and amount of insurance. If a policy is issued, the deposit will be applied to payment of the premiums thereon from its date, otherwise the deposit will be returned to the payer thereof upon surrender of this receipt."

It was stipulated that the application had neither been "accepted or approved" by the company nor had it ever been rejected by the company.

The court ruled, page 91, that:

> "The provisions of the receipt are obviously ambiguous and susceptible of two different constructions. It was possible for the appellee, as composer of the provisions of the receipt, to have been clear and thereby to avoid ambiguity. 'An insurer will not be permitted to benefit from an ambiguity of his own creation.' "

And the court held, page 91, that under an agreement couched in such language

> "the parties will be deemed to have intended to effect a present contract of interim or temporary insurance on the life of the applicant, to commence immediately upon the signing of the application and payment of the initial premium."

The insinuation that the later Ohio case of *Leube* v. *Prudential Insurance Company of America,* Ohio St. , 72 N. E. (2d) 76 (1947) (petitioner's brief, page 34) somehow departs from the sound law of the *Duncan* decision is wholly misleading. In the *Leube* case the court expressly reaffirmed the Duncan holding but ruled that it could not avail the plaintiff because the company had rejected prior to the applicant's death.

There can be no sound argument that the receipt in the *Duncan* case and the receipt in this case are not precisely the same in their legal effect. The company may argue that the words "but if death occurs after the date of the application from which this receipt is detached

and prior to the date of issue of such policy, payment in accordance with and subject to the conditions and provisions of the policy applied for shall be made;" do not appear in the application form signed by James A. Gaunt, Jr. That is true, but in our application the company warrants that "the insurance applied for shall be in force as of the date of completion of said Part B". Perhaps the company, as the result of the *Duncan* decision, thought it would be a clever move to substitute, in subsequent forms, this latter provision for the quoted provision in use at the time of the *Duncan* application. But what is the "insurance" referred to in our application? Was it not "life insurance"? And is not "life insurance" a promised indemnity against the contingency of death? Does it make any difference whether the company tells a man that it has "insured him against death" or tells him that in the event of his death it will pay him "in accordance with and subject to the conditions and provisions of the policy applied for"? How can the company contract to make payment in a certain amount if death should occur within a certain period and at the same time contract that no payment shall be made if death should occur within that period?

It can hardly be argued that by adding together two conditions, each of which has repeatedly been held by the courts *not* to militate against the existence of present interim insurance, the company could thereby obtain a sum total of legal effect which differs in substance from the legal effect of its individual components. This fact in itself would appear to provide an answer on this issue. Yet there is even a simpler and more logical solution to the problem, and that is reached by merely applying the time-tested rules of construction to the language of the instruments which are involved in the present case.

The Law Re Ambiguities and Repugnancies.

It would appear that the initial step to be taken by any court in determining the legal effect of written words, the meaning of which is in issue, is, by ascribing to each of the words its normal meaning and significance, to decide whether there is any occasion to apply accepted rules of construction.

> "The courts may resort to construction, in the usual sense, of a contract of insurance only when the language of the contract *in its ordinary meaning* is indefinite, ambiguous, or equivocal; if the language employed is clear and unambiguous there is no occasion for construction or the exercise of a choice of interpretations." (Italics ours.)
>
> *44 C. J. S.* 1139.

Language must be given its ordinary meaning unless a technical or special meaning is clearly intended and "words are to be construed according to their strict and primary acceptation" except where extraordinary circumstances clearly indicate a meaning other than the accepted one.

> *Wood* v. *Employers' Liability Assurance Corporation,* 41 Fed. (2d) 573, 575 (1930);
> *Trumbull Electric Mfg. Co.* v. *John Cooke Co.,* 130 Conn. 12, 16, 31 Atl. (2d) 393 (1943).

It seems to us that the practical application of these principles in the present case would be as follows: A reading of Question 12 indicates that the company clearly intended to give the applicant a choice as to the effective dates of his insurance. All of the words used in Question 12 are simple enough and, we submit, have an established meaning in the English language. It would hardly seem necessary to resort to a dictionary to determine their definitions. Yet we must do this because the peti-

tioner has taken the position that the word "insurance" has a meaning which was heretofore unheard of by us. We therefore look to *Webster's New International Dictionary, Second Edition,* and find that the primary definition of the word is given as follows:

> "INSURANCE. 1. Act of insuring, or assuring, against loss or damage by a contingent event."

Not trusting entirely to Webster, we look to the outstanding lawyers' handbook on legal definitions, *Bouvier's Law Dictionary, Unabridged, Rawle's Third Revision,* Vol. I, page 1613, and find the following:

> "Insurance. A contract whereby, for an agreed premium, one party undertakes to compensate the other for loss on a specified subject by specified perils."

Although, after reading some of the unique arguments advanced by the petitioner in some of its briefs on this case, we have sometimes wondered whether it would actually concede that these papers deal with life insurance, there would really seem to be little room for dispute as to the significance of the election permitted by Question 12.

We next turn to the printed matter which follows Question 18 and find in Section A thereof an agreement that the application shall be deemed to be "a part of the *contract of insurance.*" Presumably the word *insurance,* as used in that sentence, has the same significance which must be ascribed to it in Question 12. And it also might be noted that, as the word *policy* is absent from this sentence, the company must be assumed to have contemplated that insurance coverage might result from something other than the formal execution and delivery of a policy.

Coming to Section B of the same paragraph, we arrive at the very crux of this case. Even a cursory glance at the first sentence of Section B demonstrates that under

certain conditions "the insurance applied for shall be in force as of the date of completion of said Part B" (the medical examination form). Here again we find the word *insurance* and the insurance spoken of is that which has been *applied for,* so, in this instance, it presumably means the petitioner's $15,000 "Endowment at Age 85" contract with double indemnity, for surely nothing else was "applied for" by this applicant. Here also we find the term *"shall be in force",* language which is peculiarly appropriate in describing the effective period of insurance contracts. We next examine the conditions which must be met before the insurance can be in force from the date of Part B and find that they are:

1. That "the first premium or installment thereof above stated was paid when this application was signed". This condition was admitted by the petitioner, and specifically found by the court, to have been complied with. (Finding, Paragraph 13).

2. That the company be "satisfied that on the date of the completion of Part B" the applicant was "insurable in accordance with the Company's rules for the amount and on the plan applied for without modification". This condition was specifically found by the trial court to have been complied with. (Finding, Paragraphs 28, 50 and 51).

3. That the "application, including said Part B", be, prior to the applicant's death, "approved by the Company at its Home Office". Although the medical department of the petitioner's home office had positively approved this application on the morning of August 26, 1943, this act took place after the applicant's death. Thus, as we have made no effort at any stage of this case to distort the plain English meaning of any of the words in the application and binding receipt, we could not and cannot contend that this condition had been complied with.

4. That (as set forth in the last clause of the sentence) the application shall not provide for the insurance

to be in force as of the date of policy issue. It will be noted that the trial court found (Record, Part I, page 40) that the application, as executed by the applicant—and he was the only one who *could* execute it—and prior to the surreptitious unauthorized modification by Kelman, left Question 12 unanswered. Thus, this condition had also been specifically complied with.

Now if the third condition, *i. e.*, the "approval" proviso, is a valid condition precedent to the inception of any contract of insurance, then obviously we have no case. However, if this condition must be taken literally, then all of the rest of the context in which it appears becomes quite meaningless. For, if no insurance could start until the date of approval at the home office, a date concededly some, and perhaps many, days subsequent to the date of Part B, then it is surely apparent that that portion of the context providing for insurance from the date of Part B is meaningless. Thus, the presence of the "approval" proviso creates an ambiguity in the context, is wholly out of line with the other portions thereof and is utterly repugnant to them. Accordingly, the situation is a proper one for the application of the rules governing the construction of such writings.

3 C. J. S. 1037.

> "The general rule of construction applied by the courts to all contracts of insurance is that while like other contracts they are to be so construed as to give effect to the intention of the parties, yet where there exists any doubt as to that intention it is always to be resolved strictly against the insurer and in favor of the insured."

Vance on Insurance, Second Edition, page 689.

And see

Dresser v. *Hartford Life Insurance Co.*, 80 Conn. 681, 70 Atl. 39 (1908).

"The rule has also been stated that where the

policy is so drawn as to require construction it will be construed in favor of insured; and that, where it is fairly susceptible of such an interpretation, it will be construed so as to afford protection to insured, or to permit him to recover for his loss, or to sustain, rather than defeat, his claim for indemnity under the policy, or the rule will be construed by the courts to allow a greater indemnity."

44 C. J. S. 1179-1180.

"To hold the insured strictly to terms in the choosing of which he had no part, and the meaning of which he often cannot understand, would often work gross injustice which the courts are loath to inflict."

Vance on Insurance, supra, page 201.

"The rule of construction in favor of the insured is applicable to applications for insurance as well as to insurance policies themselves. An application for insurance prepared by the insurer, or a question in an application for insurance which is propounded and formulated by the insurer, where it is ambiguous, will be construed most strongly against it and in favor of the insured. The applicant is also entitled to the benefit of any ambiguity in the terminology of conditional receipts in effect pending the issuance of life, health or accident policies. For instance, any doubt as to whether a binder receipt issued for the initial premium pending an application for a life insurance policy operates to put the insurance into immediate effect must be resolved against the insurer."

29 American Jurisprudence, 187.

"The rule of strict construction against insurer and liberal construction in favor of insured applies to all parts or provisions of an insurance contract or policy *including words or terms,* phrases susceptible of more than one construction, and sentences, or *clauses* of doubtful meaning or susceptible of more than one construction; * * * *conflicting, inconsistent or repugnant provisions* * * * and even questions and answers or other statements, in the application, of doubtful meaning." (Italics ours.)

44 C. J. S. 1180-1183 (the reference to inconsistent or repugnant conditions being supported by 45 Federal and State decisions in footnote 76, pages 1182-1183).

The foregoing principles and rules appear to be universally accepted.

13 C. J. 535, 536; 1152-1155;
29 American Jurisprudence, Insurance, Section 166;
Annotation, 153 A. L. R. 794, 801;
Porto v. *Metropolitan Life Insurance Co.,* 120 Conn. 196, 200, 180 Atl. 289 (1935);
Fogarty v. *Fidelity & Casualty Co.,* 120 Conn. 296, 303, 180 Atl. 458 (1935);
King v. *Travelers Insurance Co.,* 123 Conn. 1, 6, 192 Atl. 311 (1937).

When faced with a problem of this kind the objectives of the court are, of course, to determine the true intention of the parties and, by considering all of the circumstances under which the agreement was executed, to give it a fair and reasonable legal effect.

New Britain Real Estate & Title Co. v. *Hartford Acceptance Corporation,* 112 Conn. 613, 615, 153 Atl. 658 (1931).

In attempting to reach this objective the court may use extrinsic evidence and other "secondary" rules of construction.

Adams v. *Turner,* 73 Conn. 38, 45, 46 Atl. 247 (1900);
Trumbull Electric Mfg. Co. v. *John Cooke Co., supra,* at page 17 in the Connecticut Report;
33 C. J. 115.

The real significance of the agreement here in question is, we submit, made readily apparent by merely considering the aims of the two parties, *i. e.*, the applicant wants immediate protection and is willing to advance his money to secure that objective, whereas the company, like all insurance companies, desires the new business and is willing to make certain concessions if it can get an immediate premium payment and thereby obtain security against the possible inroads of competitors before the actual date of policy issue and delivery. This is a matter of common knowledge as will be confirmed by many of the millions who have felt the pressure of life insurance solicitors, most of whom say, in effect, "It would be wise for you to pay the first premium now so that we can bind this agreement. If you do that and you are insurable the company will pay your beneficiary even if you should be killed on your way home tonight and before the home office has received the papers." It is, therefore, scarcely necessary to invoke the help of the "secondary" aids to construction. However, as some of these fit so plainly into the pattern of the present argument, we think it would not be amiss to mention two or three of them:

(a) A construction adopted by the parties.

The Finding and Amendments to Finding (Record, Part I, pages 44 and 71) make it perfectly clear that the parties to the present transaction understood and intended, at least at the time of execution of the papers, which was prior to Kelman's fraudulent alteration thereof, that it should put the insurance in force from August 3, 1943, the date of Part B, if the applicant was then an insurable risk. (Of course, the full picture as to insurability on that date would not be developed until some days later, as was understood by both parties, and the application permitted the insurer to gather further information on that point. But had the applicant been killed five minutes

after leaving Dr. Sandulli's office, the opportunity for determining insurability as of that day would thereby be diminished hardly an iota.) This method of determining the intention of the parties in ambiguous contracts has not infrequently been adopted by the courts.

44 C. J. S. 1139.

(b) Construction by the insurer's agent.

There is, of course, language in the application (Section C) which purports to restrict the authority of company representatives in various respects. However, there would seem to be nothing in these restrictions which would limit the apparent authority of any soliciting agent to describe and explain and, if necessary, to construe and interpret, the product which he is attempting to sell for his principal. It would be obviously impossible for any life insurance company or, indeed, any company which sells its products through field representatives, to operate efficiently without delegating such power and authority to its agents. These natural assumptions should be sufficient without more but, in this instance, Kelman's apparent authority is confirmed beyond doubt to have been actual authority because the trial court found (Record, Part I, page 44, Paragraph 14) that "the company sales force is instructed to stress the claimed advantage to the applicant of coverage from the time of the medical examination upon the payment of the premium at the time of application." This being so, how can there be any question but that his advice to the applicant, *i. e.*, that the payment of the first premium would effect immediate insurance protection, is binding upon the company he represented?

> "• • • And representations as to the scope of a policy, or the risks covered, made by an agent authorized to solicit insurance, take applications, collect and remit premiums, and deliver policies, and which

apparently are within the scope of his authority, to one whom he solicits, and who relies thereon, are binding upon the insurance company."

Couch, Cyclopedia of Insurance Law, Vol. 2, page 1622.

See also:

Vance on Insurance, Second Edition, pages 418-419;

Kendrick v. *Mutual Benefit Life Insurance Co.,* 124 N. C. 315, 32 S. E. 728 (1899);

Edwards v. *Masonic Mutual Life Ass'n,* 86 W. Va. 339, 103 S. E. 454 (1920);

Brady v. *Bankers Casualty Co. of Minneapolis,* 114 Kans. 865, 220 P. 1033 (1923);

Schulz v. *Benefit Ass'n of Railway Employees,* 175 S. C. 182, 178 S. E. 867 (1935).

In *Dresser* v. *Hartford Life Insurance Co.,* 80 Conn. 681, 70 Atl. 39 (1908), the insurer's prospectus, which purported to explain the terms of its contract, the latter being ambiguous in form, was given controlling weight in determining the proper construction to be placed on the instrument.

Whether the binding effect of the agent's construction of an ambiguous instrument be grounded upon apparent authority, actual authority or estoppel would seem to be immaterial.

(c) Legal effect determined by reference to prior judicial construction.

At the time it entered into its agreement with the applicant, this company had had almost precisely the same form of application, replete with the same contradictory clauses, judicially construed in *Duncan* v. *John Hancock Mutual Life Insurance Company, supra,* and thus was

aware that the agreement was, in the eyes of the law, an insurance contract from the moment of its execution if the applicant was insurable.

> "If the insurer continues to issue, without change, policies, clauses of which have been judicially construed, it will be considered as issuing them with that construction placed on them even though such construction violates the literal sense of the words used."
>
> *44 C. J. S.* 1154.

The Trial Court's Decision.

One of the most paradoxical aspects of this entire case is the petitioner's resolute insistence that the trial court was right while, at the same time, it derides the very essence of the reasoning used by that court in reaching its decision. This situation has logically developed out of the two wholly inconsistent positions which petitioner's counsel assumed in his initial approach to the problem of construction. He argued in the District Court that the application and binding receipt constituted an agreement which, he contended, was not a contract of life insurance, but rather an agreement under which the applicant, by paying his first premium in advance, was given a *quid pro quo* in the form of certain "legal benefits" or "advantages". For example, he said, one such "advantage" would be the legal right to have insurability determined as of the date of medical examination so that if the applicant became uninsurable between that date and the date of policy issue he would still be entitled to his policy. Later, because he wished to argue that the Gaunt boy became uninsurable after August 3rd because he gave up his job and started on a trip to the West Coast, counsel abandoned his claim as to this particular "advantage". Yet the District Court adopted counsel's line of reasoning and ruled, in its decision of April 17, 1946, that the instruments constituted a contract. In so doing, the court

found that the instruments were of doubtful meaning but, in a construction which it admitted was "strained", held that the words "the insurance applied for shall be in force as of the date of completion of said Part B" actually meant that the so-called "advantages" were what the applicant received under the contract.

The conclusion that a contract existed between the insurer and the applicant as of August 3, 1943 was obviously correct. The payment of the first quarterly premium and the decision by the applicant to give up his pending efforts to obtain his life insurance elsewhere were detriments to himself and benefits to the petitioner. The petitioner's agreement to give something in return was a detriment to the petitioner and a benefit to the applicant. These various benefits and detriments were simultaneously exchanged. Thus every element essential to the formation of a contract was present. Notwithstanding the petitioner's efforts to hedge and to becloud the insured's rights under these instruments, it is of the greatest significance to note that its legal experts used the words "in consideration of" in the binding receipt in describing the benefits which were to inure to the applicant in return for his immediate premium payment. These words are not often used by legal draftsmen in instruments which are other than contracts.

The reason that the trial court "strained" the words "insurance applied for" by defining them in terms hitherto unheard of was that it, for some reason which we have never understood, felt obliged to leave the wording of the contract intact and to give every word some significance however illogical it might be. In so doing the court felt that it would then be able to interpret the approval condition *in its literal sense*. Just why the words which most favored the company should be treated in their dictionary sense while the words which most favored the applicant should be distorted to mean something which no ordinarily intelligent person would understand them to mean has never been explained. In so do-

ing, the District Court destroyed the respondent's case. But by doing so it also, quite unwittingly, completely refuted its earlier correct premise that the documents constituted a *contract*. For, under the court's construction, the petitioner retained the complete, unfettered right to reject the application for any reason or no reason. Of what avail then were the "advantages" which the applicant obtained under his "contract"?

In a brief filed in support of a motion to correct the findings and modify the judgment, we advanced the foregoing arguments in considerable detail. It seemed to us that if we could but persuade the trial judge that the one possible, proper legal construction of this contract could be reached only through the simple and required process of deleting, in effect, the repugnant "approval" proviso, then we must prevail. We therefore placed considerable emphasis upon the undisputed rule governing repugnancies and the cases which support it.

This rule is of course that where there are two or more conflicting or inconsistent provisions in an insurance agreement that one most favorable to the insured should be adopted to the exclusion of the other.

Prudential Insurance Co. of America v. *King* (C. C. A. Mo.), 101 F. (2d) 990 (1939);

New York Life Insurance Co. v. *Jackson* (C. C. A. Ill.), 98 F. (2d) 950 (1938);

Harvey v. *Union Central Life Ins. Co.*, C. C. A. S. C., 45 F. (2d) 78, certiorari denied *Union Central Life Ins. Co.* v. *Harvey*, 51 S. Ct. 353, 283 U. S. 829 (1931);

Sovereign Camp, W. O. W. v. *Hardee*, 188 Ark. 542, 66 S. W. (2d) 648 (1934);

National Equity Life Ins. Co. v. *Bourland*, 179 Ark. 398, 16 S. W. (2d) 6 (1929);

New York Life Ins. Co. v. *Bird*, 152 Fla. 532, 12 So. (2d) 454 (1943);

Kimbal v. *Travelers Ins. Co.*, 151 Fla. 786, 10 So. (2d) 728 (1942);
Fokes v. *Interstate Life & Accident Ins. Co.*, 59 Ga. App. 680, 2 S. E. (2d) 170 (1939);
American Inv. Co. of Ill. v. *U. S. Fidelity & Guaranty Co.*, 267 Ill. App. 370 (1932);
Hungate v. *New York Life Ins. Co.*, 267 Ill. App. 257 (1932);
Nalty v. *Federal Casualty Co.*, 245 Ill. App. 180 (1927);
Bean v. *Aetna Life Insurance Co.*, 111 Tenn. 186, 78 S. W. 104 (1903);
Jones v. *Pennsylvania Casualty Co.*, 140 N. C. 262, 52 S. E. 578 (1905).

This reasoning clearly influenced the District Court for, although it failed to reverse the judgment, it filed a second memorandum of decision on July 23, 1946 (Record, Part I, page 75) in which it discarded the "contract" theory of "advantages" and simply ruled that because of the presence of the "approval" condition the respondent could not prevail. In this new and wholly negative approach, the District Court made no effort to say what the contract means; it merely set forth what it did *not* mean. Thus the ultimate result in the District Court was a final judgment without affirmative analytical support. It is not difficult to ask: How could the "layman" upon reading the approval proviso consider that he had insurance in force from the date of Part B? But this ignores the remaining and much more important question: How could the layman read the "insurance in force as of" provision and *not* conclude that he had insurance in force as of the date of Part B? It also ignores the legal effect of the agent's representations and the company's specific authorization to its agents to solicit immediate premium payments in exchange for the benefits of immediate protection. Therefore, in its final form, the lower court's decision said no more than: "The court

refuses to hold that the 'approval' provision is not effective and therefore the plaintiff cannot recover." This, we submit, was not a fulfillment of the court's function, for that function was to announce to the parties, after proper application of the controlling principles and rules of law, an affirmative statement of the meaning and legal significance of the parties' contract. The court's dilemma was plain, for once it had determined to save and give effect to the repugnant clause at all costs, it had no alternative but to avoid a positive reasonable construction of the entire contract.

The second memorandum of the District Court had this effect, however. It finally convinced even petitioner's counsel that the Circuit Court of Appeals would be most unlikely to accept the argument on "legal benefits", *i. e.*, a contract for "advantages" but not insurance, which he had persuaded the District Court to adopt in its first memorandum. He therefore dropped that notion and in the Circuit Court of Appeals concentrated, as he does here, upon the concept of the application and binding receipt as evidencing a mere *offer* to his client.

In the light of this marked change in petitioner's attitude toward the problem, its counsel's repeated assertions that the District Court's decisions constituted an authoritative pronouncement of Connecticut law are most unconvincing. In passing, it seems hardly necessary to remind the Court that the conclusions of the District Court Judge on the question of construction are not only unsupported by reference to Connecticut cases, of which there are none which would be helpful; there are, in fact, *no cases* cited in support of those conclusions.

The solution was and is not a difficult one: Eradicate the unfair and repugnant condition and the contract stands as a sensible, reasonable agreement, wholly consistent with the intentions of the parties and their obvious objectives. So construed and with the question of insurability determined in the respondent's favor, as it has been, the agreement is a binding, preliminary contract of life insur-

ance quite similar to those discussed in *Reynolds* v. *Northwestern Mutual Life Insurance Company* and *Stonsz* v. *Equitable Life Assurance Society of U. S., supra,* page 25. This, in substance, was what the Circuit Court of Appeals did and in so doing it simply followed the pertinent decisions of other jurisdictions and those universally accepted principles of insurance contract construction which are the law of Connecticut and every other jurisdiction in this country.

Insurability.

The District Court's finding of insurability was a finding which, as appears in the record, could not have been otherwise even if the actions and words of the petitioner's own representatives, investigators and underwriters were the sole basis for it.

Without doubt, the attack on the finding of insurability is the most absurd and unfounded of the many dubious contentions which appear in the petitioner's brief. In the first place, the contract categorically provides that the determination of insurability shall depend upon the rules of insurability of the John Hancock Mutual Life Insurance Company and not upon the rules of the Lincoln National Life Insurance Company, or any other company. Furthermore, as paragraph 6 of the District Court's finding (Record, Part I, page 38) clearly shows, the petitioner's rules permitted the issuance of up to $70,000 in life insurance upon the life of an applicant of the decedent's age. There was no qualification to this rule but, as shown in the same paragraph of the finding, there was simply a second rule, not referred to in the contract, under which the petitioner would reinsure any amount over $10,000. The applicant, being insurable under the petitioner's rules, the latter could have automatically bound the Lincoln National to the excess $5,000 or it could have submitted the proposition to Lincoln on a facultative basis. What Lincoln would have done or would not have

done is of absolutely no consequence for the real question was whether this applicant was physically, morally and financially insurable *under the petitioner's rules relating to insurability.* However, even if the Lincoln's attitude were to be regarded as a relevant factor on the issue of insurability, the District Court, in paragraph 51 of its finding (Record, Part I, page 51) found that Lincoln would have accepted the risk for the additional $5,000 with double indemnity and would have so notified the petitioner within three days after the receipt of the file and request. Contrary to what the petitioner would, by implication, have this Court believe, the finding of fact in paragraph 51 was fully supported by expert testimony during the trial in the District Court. And no effort has ever been made by the petitioner to seek an appellate review of this evidence. The argument that because no representative of Lincoln National testified in the trial, it was not possible for the District Court to conclude that Lincoln would have accepted the risk, is as wholly unsound in law as would be the claim that the applicant could not have been found insurable under the petitioner's rules simply because its underwriter, in retrospect, might testify to the contrary. The conclusions of the District Court on the matter of insurability in both the petitioner company and the Lincoln National were based upon the expert testimony of a disinterested witness and as such are hardly subject to impeachment at this late date.

VI.

Conclusion.

As was well stated by Hon. Joseph C. Hutcheson, Jr., Judge of the United States Circuit Court of Appeals, Fifth Circuit, in an article entitled "Law and Fact in Insurance Cases" appearing in 23 Texas Law Review, December, 1944, pages 1 to 17:

"One of the main sources of the difficulties in the

matter of insurance contracts is the difference between the atmosphere in which a policy is issued and that in which losses are settled for. The atmosphere in which it is written is the atmosphere of selling, roseate with promises, express or implied, and the insured, like the sheep before the shearer, opens not his mouth."

* * * *

It is plain that the action of the Circuit Court of Appeals furnishes this petitioner with no ground for certiorari under any of the rules which have been enunciated by this Court up to the present time. Had the Circuit Court of Appeals decided against the respondent, *she* might well have contended that the case was of such general public interest as to merit further review, for a decision against her would have meant that immunity from liability, accomplished by means of the tricky wording of an insurance contract in ambiguous and repugnant terminology, had received judicial countenance. The converse proposition, however, coming from this insurer, is hollow and unjustified, for it can so readily remedy the evil it has created by modifying its forms so that the public will not henceforth be deceived. The petitioner, having resisted its just liability on every tortuous theory that it was able to devise, could hardly have expected that it would be commended by the Circuit Court of Appeals. That court, if it erred in any respect, was guilty only of a modest understatement when it described the petitioner's conduct as "unpardonable".

Respectfully submitted,

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